Abiy Meshesha, M.D., Inc.
General Surgery, Laparascopic Surgery, Robotic Surgery and Surgical Oncology

Patient Information

First Name: ____________________________________ Last Name: ___________________________________

Previous Name: _________________________ Date of Birth: ____/_____/________ Sex: Male___ Female____

Social Security Number: ______-_____-_______ Marital Status: Single___ Married___ Divorced___ Widowed__

Address: ____, Apt#: ________________

City: ____State:____________ Zip Code: ________________

Home Phone Number: _________________________ Cell Phone Number: ________________________________

Work Phone Number: ______________________________ Fax Number: _________________________________

Email Address: ____

Primary Care Physician Name: ____

Emergency Contact Person:

First Name: ____________________________________ Last Name: _____________________________________

Address: ____, Apt#: ________________

City: ____State:____________ Zip Code: ________________

Telephone Number: ___________________________ Email Address: ____________________________________

Relation to patient: ___________________ Release of information: Allowed__ Restricted Release__, No Release__

Employment Status:

Employed: _______Unemployed_______ Retired: _________

Employer Name: ____

Address: ____, Apt#: ________________

City: ____State:____________ Zip Code: ________________

Telephone Number: ___________________________ Email Address: ____________________________________

Current Medication:

Name of Medication	Dose	Frequency

Medical History:

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Name of the illness	Date of Diagnosis

Allergies/Intolerance:

Agent/Substance	Reaction

Surgical History:

Date (Mo/Yr)	Surgery

Hospitalization:

Date (Mo/Yr)	Reason for hospitalization

Family History:

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Relationship	Status:	Alive Deceased Unknown	Age	Any Illness
Father				
Mother				
Grandfather				
Grandmother				
Sibling #1				
Sibling #2				
Sibling #3				
Aunt				
Uncle				
Cousin				

Social History:

1. History of Tobacco Smoking

 Do you smoke cigarettes: Yes______ No______

 If you are a current smoker, How may cigarettes per day ______Are you interested in quitting ___

 If you are a former smoker, how long has it been since you last smoked? ____________________

2. History of Alcohol

 Do you drink alcohol: Yes______ No______

 How often do you drink?

 Monthly or less ___2-4 times a month ___2-3 times a week ___4 or more times a week ___

 How many drinks on a typical day

 1-2 drinks ___3-4 drinks ___5-6 drinks ___7-9 drinks ___10 or more drinks ___

3. **Do you use recreational drugs:** Yes_____ No______

Name of the drug:	**Date last used:**
Marijuana	
Cocaine	
Methamphetamine	
Heroin	
Prescription Opiates?	

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4. Do you have children: No______ Yes ______If yes, how many? ________________________________

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Review of Systems

General:

Symptom	Yes	No
Change in weight		
Weight loss		
Change in appetite		
Fatigue		
Fever or chills		
Night sweats		

HEENT:

Symptom	Yes	No
Blurred vision		
Eye discharge		
Difficulty hearing		
Ear pain		
Ear discharge		
Nose bleeding		
Gum bleeding		

Respiratory:

Symptom	Yes	No
Cough		
Shortness of breath		
Wheezing		

Gastrointestinal:

Symptoms	Yes	No
Abdominal pain		
Nausea and/or vomiting		
Diarrhea		
Constipation		
Heartburn		
Rectal bleeding		
Perianal discharge		

Genitourinary

Symptoms	Yes	No
Blood in urine		
Frequency		
Pain during urination		

Musculoskeletal:

Symptoms	Yes	No
Painful joints		
Swollen joints		
Muscle ache		

Skin

Symtpoms	Yes	No
Rash		
Skin lesion		

Neurologic

Symptoms	Yes	No
Headache		
Seizure		
Gait abnormality		
History of stroke		

Cardiovascular:

Symptoms	Yes	No
Chest pain		
Difficulty to sleep without pillows		
Palpitation		

I hereby authorize Abiy Meshesha, M.D., Inc to examine me and render treatment as deemed necessary.

Signed: ________________________________ **Date:** ________________________